DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 1 0 1 0

2. STATE: California

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 1, 2001

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 U.S.C. 1396a

7. FEDERAL BUDGET IMPACT:
a. FFY 2001-02 $ ~~Unknown~~ $ 2.6 million PSD
b. FFY 2002-03 $ ~~Unknown~~ $ 2.6 million

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B Page 6 - 6G PSD

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-B Page 6

10. SUBJECT OF AMENDMENT:

Benefits Improvements and Protection Act (BIPA) reimbursement requirements for Federally Health Centers (FQHCs) and Rural Health Clinics (RHCs)

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: Governor's office does not wish to review State Plan Amendments.

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Gail Margolis

13. TYPED NAME:
Gail L. Margolis

14. TITLE:
Deputy Director

15. DATE SUBMITTED:
3/29/01

16. RETURN TO:
Department of Health Services
Attn: State Plan Coordinator
714 P Street, Room 1640
Sacramento, CA 95814

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: March 29, 2001

18. DATE APPROVED: 12/19/01

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
January 1, 2001

20. SIGNATURE OF REGIONAL OFFICIAL:
for Jane L. Minamoto

21. TYPED NAME:
Linda Minamoto

22. TITLE: Associate Regional Administrator
Division of Medicaid

23. REMARKS:
Block 7 - Estimate provided by DHS on 12/6/01.
Block 8 - Revised to reflect material submitted by DHS on 12/4/01.

FORM HCFA-179 (07-92)

Instructions on Back

STATE PLAN AMENDMENT
PROSPECTIVE PAYMENT REIMBURSEMENT

A. General Applicability

1. Notwithstanding any other provision of this State Plan, reimbursement to all Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) for the types of services described in this Supplement will be made as set forth below. This Supplement will apply to Medi-Cal Services furnished to Medi-Cal beneficiaries for purposes of implementing Section 702 of the Medicare, Medicaid, and State Child Health Insurance Program Benefits Improvements and Protection Act of 2000 (BIPA 2000).

2. Provisions of this Supplement will not apply to FQHCs (or "FQHC look-alike clinics," as defined in Section 1905(l)(2)(B) of the Act) that participate under the California Section 1115 Medicaid Demonstration Project for Los Angeles County – No. 11-W-00076/9 (Project Extension effective July 1, 2000 to June 30, 2005) and receive 100 percent cost-based reimbursement under the Special Terms and Conditions of that waiver. FQHCs (or "FQHC look-alike clinics") under the Demonstration Project and holding contracts with Los Angeles County will have the option of continuing to receive cost-based reimbursement or converting to one of the payment methodologies described under Section D, Section E, or Section F. Any FQHC as described in this paragraph that fails to make an election within 30 days of written notification from the Department of Health Services (DHS) will, by default, receive Prospective Payment System (PPS) reimbursement, as described in Section D.

3. Any facility that first qualified as an FQHC or RHC (as defined in Section B) prior to the close of its fiscal year ending in calendar year 2000 will be reimbursed through the prospective payment methodology described under Section D, unless within 30 days of written notification from DHS the facility elects to be reimbursed under the alternative payment methodology described under Section E. If the alternative payment methodology described under Section E is selected by the facility, the initial selection of a payment methodology will remain in effect through September 30, 2002. (See subsection A.4 for a description of prospective reimbursement after September 30, 2002.)

4. Prior to October 1, 2002, each FQHC and RHC must inform DHS as to whether its base rate (which will serve as the basis for all future Medicare Economic Index (MEI) increases and scope-of-service changes) will be the rate calculated using the prospective payment methodology described under Section D, or the alternative payment reimbursement methodology described under Section E. For purposes of this supplement, the MEI for a particular calendar year is defined as the percentage increase in the MEI

(as defined in section 1842(i)(3) of the act) applicable to primary care services (as defined in section 1842(i)(4) of the act) for the particular calendar year as published in the Federal Register. The base rate selected for purposes of reimbursement will be inclusive of the MEI increases that were applied prior to October 1, 2002, described under Section D and Section E, respectively. An FQHC or RHC that fails to notify DHS of its election of the alternative payment methodology within 30 days of written notification will, by default, be assigned a base rate calculated using the prospective payment methodology described under Section D.

5. To the extent that FQHCs and RHCs have been designated as provider-based entities under Medicare, pursuant to Health Care Financing Administration Transmittal No. A-98-15, May 1998, the FQHC's or RHC's prospective rate will be based on its provider-based status. In addition, an FQHC or RHC that was provider-based as of July 1, 1998, or that had provider-based status pending on April 22, 1999, and has received Medi-Cal payments based on its provider-based status continuously since that date, will continue to be paid prospective rates in accordance with provider-based status.

B. FQHCs and RHCs Eligible for Reimbursement under this Supplement

FQHCs and RHCs eligible for prospective or alternative payment reimbursement are those defined as a "Rural Health Clinic" or "Federally Qualified Health Center" in section 1905(l)(1), and section 1905(l)(2)(B), respectively, of the Act.

C. Services Eligible for Reimbursement under this Supplement

1. Services eligible for prospective or alternative payment reimbursement are those described in section 1905(a)(2)(C) of the Act that are furnished by a FQHC and services described in section 1905(a)(2)(B) of the Act that are furnished by a RHC. The services furnished will be reported to DHS annually in a format prescribed by DHS.

2. A "visit" for FQHC or RHC services is defined as follows:

   (a) A visit is defined as a face to face encounter between an FQHC or RHC patient and a physician, physician assistant, nurse practitioner, certified nurse midwife, clinical psychologist, licensed clinical social worker, or visiting nurse, hereafter referred to as a "health professional," to the extent the services are reimbursable under the State Plan. A physician means:

      (i) A doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State and who is acting within the scope of his/her license.

(ii) A doctor of podiatry legally authorized to practice podiatric medicine by the State and who is acting within the scope of his/her license.

(iii) A doctor of optometry legally authorized to practice optometry by the State and who is acting within the scope of his/her license.

(iv) A doctor of chiropractics legally authorized to practice chiropractics by the State and who is acting within the scope of his/her license.

(v) A doctor of dentistry legally authorized to practice dentistry by the State and who is acting within the scope of his/her license.

(b) A visit also includes services provided by a Comprehensive Perinatal Services Practitioner as defined in the California Code of Regulations, title 22, section 51179.7.

(c) Encounters with more than one health professional and multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit. One exception is allowed when the patient, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment. A second exception is when the clinic patient is seen by a health professional and dentist on the same day of service, which may be counted as two visits.

3. Notwithstanding subsection C.2, the individual licensed FQHC and RHC sites that provided Adult Day Health Care (ADHC) services to Medi-Cal beneficiaries during December 2000, may continue to be reimbursed for ADHC services on a per visit basis (in effect in December 2000) pursuant to the payment methodology set forth in this Supplement, as long as its ADHC provider status is maintained. FQHCs and RHCs that add ADHC services as a new benefit after January 1, 2001, will not be reimbursed for ADHC services on a per visit basis. Rather, those FQHCs and RHCs must submit a request to DHS for a rate adjustment in accordance with scope-of-service changes as described in Section H.

D. Prospective Payment Reimbursement

An FQHC or RHC that does not elect the alternative payment methodology under Section E will receive reimbursement under the following prospective payment methodology provisions.

1. DHS will implement a prospective payment methodology on a phased basis, commencing on July 1, 2001. Specifically, each FQHC or RHC will receive payment, in an amount calculated using the methodology described under subsections D.2 and D.3 effective the first day of its fiscal year that begins on or after July 1, 2001. For the period January 1, 2001, until the payment methodology described in this Section D becomes effective for the particular facility, each FQHC or RHC will be paid in accordance with Section F.

2. For each FQHC or RHC, the prospective payment rate for its first fiscal year (commencing on or after July 1, 2001) will be an amount that is equal to 100 percent of the average cost reimbursement rate per visit for fiscal years 1999 and 2000 for the FQHC or the RHC. Specifically, for each FQHC or RHC, the prospective payment rate for its first fiscal year will be determined by adding its visit rate for its fiscal years 1999 and 2000, and then dividing this amount by two.

3. Effective October 1st of each year, for services furnished on and after that date, DHS will adjust the rates established under subsection D.2 by the percentage increase in the MEI (as defined in Section 1842(i)(3) of the Act) applicable to primary care services (as defined in Section 1842(i)(4) of the Act) for the particular calendar year as published in the Federal Register.

4. DHS will notify each FQHC and RHC of its annual rate increase.

E. Alternative Payment Methodology

An FQHC or RHC that elects the alternative payment methodology under this Section E will receive reimbursement under the following provisions.

1. Each FQHC and RHC will be given the opportunity to elect to receive payment in an amount calculated using the alternative payment methodology described in this Section effective the first day of its fiscal year that begins on or after July 1, 2001. For the period January 1, 2001, until the payment methodology described in this Section E becomes effective for the particular facility, each FQHC or RHC will be paid in accordance with Section F.

(a) Payments made to each FQHC or RHC in accordance with the alternative payment methodology set forth in this Section E will be an amount (calculated on a per visit basis) that is equal to its reported cost-based rate for the particular facility's fiscal year ending in calendar year 2000, and increased by the percentage increase in the MEI.

(b) Each participating FQHC's or RHC's reported cost-based rate (calculated on a per visit basis) for the particular facility's fiscal year ending in calendar year 2000 will serve as its base rate under this alternative payment methodology.

(c) As described in more detail below, the base rate will be increased by the percentage increase in the MEI (as defined in Section 1842(i)(3) of the Act) applicable to primary care services (as defined in Section 1842(i)(4) of the Act) for the particular calendar year as published in the Federal Register.

(d) Effective July 1, 2001, the MEI increase will be applicable to the period starting with the mid-point of each FQHC's or RHC's fiscal year through the mid-point of the rate periods (January 1, 2001 through June 30, 2001 and July 1, 2001 through September 30, 2002). For example, if an FQHC or RHC has a June 30th fiscal year end, the period determining the first MEI increase will be December 31, 1999 (the FQHC's or RHC's fiscal year mid-point) up until April 1, 2001 (the midpoint for the rate period January 1, 2001 through June 30th, 2001). The period determining the second MEI increase will be April 1, 2001 through February 15, 2002 (the midpoint for the rate period July 1, 2001 through September 30, 2002). If an FQHC or RHC has a December 31st fiscal year end, the period determining the first MEI increase will be June 30, 2000 up until April 1, 2001. As in the previous example, the period determining the second MEI increase will be April 1, 2001 through February 15, 2002.

(e) In accordance with Section 1902(aa)(6)(B) of the Act (42 U.S.C. 1396a), in order for an FQHC or RHC to receive the rate of payment under the alternative payment methodology, such rate must be no less than the rate calculated using the methodology described in Section D.

2. Beginning October 1, 2002, and each October 1st thereafter, for services furnished on and after October 1, 2002, DHS will adjust the rates established under subsection E.1, by the percentage increase in the MEI (as specified in subparagraph E.1(c), above).

F. Alternative Payment Methodology for Retroactive Reimbursement

1. For the period January 1, 2001, until the date that a particular FQHC or RHC begins to receive payment pursuant to the methodology set forth at Section D or Section E, such FQHC or RHC may elect to retroactively receive reimbursement under Section D or Section E, or to decline such reimbursement. An FQHC or RHC that fails to make an election within 30 days of written notification from DHS will receive retroactive payment to January 1, 2001, under the prospective payment methodology described under Section D.

2. An FQHC or RHC that elects in writing to decline retroactive reimbursement under both Section D and Section E may continue to be paid under the cost-based reimbursement methodology as in effect prior to BIPA 2000 until payments under Section D or Section E take effect, subject to the requirements of Section 1902(aa)(6) of the Act, and to cost reconciliation when appropriate.

G. Rate Setting for New Facilities

1. In those cases where a facility first qualifies as an FQHC or RHC (as defined in Section B) after its fiscal year ending in calendar year 2000, DHS will require that the facility identify at least four comparable clinics or centers providing similar services in the same geographic area with similar caseloads. If no comparable clinics or centers are in operation in the same geographic area, the facility will be required to identify at least four comparable clinics or centers in a geographic area with similar socio-economic characteristics. From this information, DHS will verify the comparability of the clinics or centers and establish a new rate (calculated on a per visit basis) that is equal to the average of the rates established for the comparable clinics or centers.

2. If a facility does not respond within 30 days of DHS's request for four comparable clinics or centers, DHS will suspend processing of the facility's request for reimbursement as an FQHC or RHC, until the required information has been provided.

3. The rate established under subsection G.1 will be subject to the requirements of Section 1902(aa)(4) of the Act, and to the MEI increase as described in subsection D.3.

H. Adjustments to the Prospective Rate Setting Methodology

1. An FQHC or RHC may request an adjustment to its prospective payment rate or alternative payment methodology reimbursement rate based on a scope-of-service change. Allowable scope-of-service changes are defined

as additions of a new benefit (such as adding dental services), or the addition of new facilities or satellite service sites (including mobile facilities). In addition, DHS will take into consideration changes in the type, intensity, duration, and/or amount of services provided in its determination as to whether a change in scope has occurred. A change in the cost of a service is not considered in and of itself a change in the scope of services.

2. A written request under this Section H must be made to DHS for its consideration and include differences in costs and visits, if applicable, associated with pre- and post- scope-of-service changes utilizing a cost report format as specified by DHS.

3. An FQHC or RHC may request one rate adjustment for scope-of-service changes at any time during its fiscal year. If the rate adjustment request is approved by DHS, the rate adjustment will take effect, for services rendered, the month following DHS approval. The adjusted rate becomes the new rate subject to the annual MEI percentage increase.

4. Notwithstanding the provisions of paragraph 3, above, if the approved scope-of-service change was initially implemented on the first day of a FQHC or RHC's fiscal year ending in calendar year 2001, or on a later date that is prior to the approval date of this supplement by the Centers for Medicare and Medicaid Services, payments for services that are within such scope-of-service change (and provided on or after January 1, 2001), will be made retrospectively at the adjusted rate. The preceding sentence will become operative only if a particular FQHC or RHC elects to be reimbursed under the prospective payment methodology described in Section D or E, above, and only on and after the date that that methodology is effective for the facility.

I. Administration of Managed Care Contracts

1. Where an FQHC or RHC furnishes services pursuant to a contract with a managed care entity (MCE) (as defined in Section 1932(a)(1)(B) of the Act), DHS will make supplemental payments to the extent required by Section 1902 (aa)(5) of the Act.

2. Supplemental payments made pursuant to Section I.1. will be governed by the provisions of subparagraph (a) through (d), below.

   (a) FQHCs and RHCs that provide services under a contract with a MCE will receive, at least quarterly, state supplemental payments for such services that are an estimate of the difference between the payments the FQHC or RHC receives from MCEs and the

payments the FQHC or RHC would have received under the methodology described in Section D or Section E.

(b) At the end of each FQHC's or RHC's fiscal year, the total amount of supplemental and MCE payments received by the FQHC or RHC will be reviewed against the amount that the actual number of visits provided under the FQHC's or RHC's contract with MCEs would have yielded under the methodology described in Section D or Section E.

(c) If the amount received under the methodology described in Section D or Section E exceeds the total amount of supplemental and MCE payments, the FQHC or RHC will be paid the difference between the Section D or Section E amount calculated using the actual number of visits, and the total amount of supplemental and MCE payments received by the FQHC or RHC.

(d) If the amount calculated using the methodology described in Section D or Section E is less than the total amount of supplemental and MCE payments, the FQHC or RHC will refund the difference between the amount calculated using the methodology described in Section D or Section E (based on actual visits) and the total amount of supplemental and MCE payments received by the FQHC or RHC.

J. Payment for Services for Recipients with Medicare/Medi-Cal or Child Health and Disability Program (CHDP) Coverage

Where a recipient has coverage under the Medicare or the CHDP program, DHS will supplement the payment from those programs not to exceed the prospective payment rates established under this Supplement.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services
San Francisco Regional Office
75 Hawthorne St., Suite 408
San Francisco, CA 94105

DEC 19 2001

Gail L. Margolis, Deputy Director
Medical Care Services
Department of Health Services
714 P Street, Room 1253
Sacramento, CA 95814

Dear Ms. Margolis:

Enclosed is a copy of California State plan amendment (SPA) No. 01-010, which we have approved effective January 1, 2001, as requested. This SPA implements Section 702 of the Medicare, Medicaid and State Child Health Insurance Program Benefits Improvement and Protection Act of 2000 (BIPA). This requires Federally Qualified Heath Center (FQHC) and Rural Health Clinic (RHC) services to be reimbursed consistent with a new prospective payment system.

During the review process, several key issues were discussed with your staff that we wish to point out to ensure clarity.

- The definition of a visit, found in Section C of this SPA, applies to fiscal years 2001 and beyond. This same definition of a visit must also apply to the PPS base years of 1999 and 2000. Based upon review of "FQHC Medi-Cal Cost Report Instructions," this is the same definition of a visit that the Department of Health Services (DHS) instructed FQHCs and RHCs to use in 1999, 2000, and 2001.

- The BIPA statute requires that the PPS rate be adjusted to take into account any increase or decrease to the scope of services furnished by an FQHC or an RHC. As required, this SPA indicates that DHS will adjust the PPS and alternative rates, upon the request of the FQHC or RHC, if the facility has a change in its scope of services. Even though this SPA covers the minimum required by statute, it is not clear how these adjustments will be made and when they will be applied. DHS must develop and implement a scope-of-service change methodology. Scope of service change adjustments should be applied in accord with guidance found in CMS's Questions and Answers of September 2001.

- Section J of this SPA states: "Where a recipient has coverage under the Medicare or CHDP program, DHS will supplement the payment from those programs not to exceed the PPS rates established under this supplement." DHS has assured CMS that this section does not mean they will pay less than the PPS or alternative rates for these dually-eligible individuals. For these individuals, DHS will pay the FQHC or RHC the difference between the amount that Medicare or CHDP paid and the Medi-Cal PPS or alternative rate for the FQHC or RHC.

- On August 20, 2001 CMS sent a letter to DHS stating: "The PPS payment methodology does not preclude FQHCs/RHCs from participating in risk arrangements with MCOs or from receiving financial incentive payments from MCOs under such arrangements. Thus, policies pertaining to financial incentives as outlined in our September 27, 2000 SMDL are still applicable under BIPA." The approval of this SPA does not alter the need for California to comply with this guidance.

Questions concerning this approval should be directed to Pat Daley at (415) 744-3592.

Sincerely,

Linda Minamoto
Associate Regional Administrator
Division of Medicaid

Enclosure

cc: Elliott Weisman, CMS, Center for Medicaid and State Operations
Suzan Stecklein, CMS, Center for Medicaid and State Operations
Barbara Hardiman, DHS, California State Plan Coordinator